RHRA Retirement Homes Regulatory Authority

55 York Street, Suite 700
Toronto, ON. M5J 1R7

COMPLIANCE ORDER SUMMARY
TO BE MADE AVAILABLE IN HOME

Pursuant to the *Retirement Homes Act, 2010* S.O. 2010, Chapter 11, section 90.

King Station GP Inc.
o/a Sorrento Retirement Residence
10 Station Road
Bolton, ON L7E 4L3

COMPLIANCE ORDER NO. 2026-T0587-90-01

Under section 90 of the *Retirement Homes Act, 2010* (the "Act"), if the Registrar of the Retirement Homes Regulatory Authority (the "Registrar" and the "RHRA", respectively) believes on reasonable grounds that a licensee has contravened a requirement under the Act, the Registrar may serve an order on a licensee ordering it to refrain from doing something, or to do something, for the purpose of ending the contravention and achieving compliance, ensuring that the contravention is not repeated, and that compliance is maintained. The Registrar issues this Compliance Order (the "Order") to require King Station GP Inc. (the "Licensee") operating as Sorrento Retirement Residence (the "Home") to come into and maintain compliance with the Act and Ontario Regulation 166/11 under the Act (the "Regulation").

CONTRAVENTION

The Deputy Registrar has reasonable grounds to believe that the Licensee contravened the following sections of the Act and Regulation:

- Section 44(1)(a-c) of the Act – The Licensee did not ensure that care services are not reduced unless the resident and/or substitute decision-maker has been delivered written notice indicating the date the reduction will take effect. The Licensee did not take reasonable steps to facilitate the resident's access to any external care providers that the resident needs.
- Section 67(1) of the Act - The Licensee did not protect residents of the Home from abuse by anyone.
- Section 6 of the Regulation – The Licensee did not ensure that residents are provided with at least 90 days before the reduction in case services takes effect.
- Section 63(3)(a) of the Act and section 49(1)(a) of the Regulation – The Licensee did not provide a resident with information about alternatives to living in the Home.

BRIEF SUMMARY OF FACTS

Inspections conducted at the Home on December 11, 2025, and January 8, 2026, identified non-compliance related to behaviourmanagement and administrative charges imposed on a resident, including charges that were not supported by the Licensee's documented policies or procedures.The Licensee was also unable to provide documentation demonstrating that alternative placement options or referrals had been considered for the resident, whose behaviours could no longer be managed by the Home and who could not continue to reside there.

A third inspection, conducted on January 20, 2026, identified additional non-compliance regarding the discontinuation of care services. The inspection found that the Licensee discontinued care services for a resident without providing the required 90 days' notice. The inspection also identified that the Licensee did not take steps to arrange for a third-party care provider to provide the services to the resident.

REQUIRED ACTION

Pursuant to section 90 of the Act, the Registrar orders the Licensee to comply with the following:

1. Within 30 days of this Order, develop and implement a written protocol for the reduction or discontinuation of care services, addressing the written notice requirement, the reasons for the change, and the requirement that external care providers or appropriate alternate accommodations are identified and communicated, as applicable.

2. Within 60 days of this Order, ensure that all staff and management of the Home complete refresher training addressing how to identify, respond to and investigate suspected, witnessed, or alleged abuse.

All information demonstrating compliance with the required actions must be submitted by email to RHRA Compliance Monitoring at enforcement@rhra.ca.

Issued on June 1, 2026.